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THE PROBABLE FUTURE OF THERAPEUTICS.

BY JAMES ROBIE WOOD, M. D., I.L. D., NEW YORK.

PART IV—GENERAL THERAPEUTICS.

- A.—Justice to Medical Benefactors.
- B.—Medical and Surgical Colleges of the Future.
- C.—Restoration of Ancient Systems and Medicines in Improved Forms and Applications.

"If there be a crime of deeper dye
than all the guilty train of human vices
'tis ingratitude."

UNGRATEFUL EXPERIENCES ABOUT OUR BENEFACTORS.

Doctor Samuel Johnson was present at a large tea party when Master M., who had been plaguing several of the guests, said to his mother that he would be good if she would give him an apple.

"My dear child," said the parent, feeling herself in the presence of a great moralist, "you ought not to be good on any consideration of gain, for 'virtue is its own reward.' You

ought to be good disinterestedly and without thinking of what you are going to get for it."

"Madame," said Doctor Johnson, "you are a fool; would you have the boy be good for nothing?"

This aptly applies to recent utterances of persons whose peculiar interpretation of medical morality makes no distinction between dis honorable practice and common justice.

Some selfishly demand that the results of the most laborious work of men of brains and originality shall be freely given for the use and profit of physicians, without other compensation than honorable mention, and even this empty honor is often rendered only under the compulsion of public opinion. In the words of Sam Johnson, such fastidious moralists

insist that human benefactors shall be "good for nothing!"

For many years scores of able, painstaking and indefatigable scientists in Europe have given their best energies for the advancement of medical knowledge. In some cases these men have resigned lucrative practice in order to devote mind, heart and soul wholly to their noble vocation.

Of these, one to whom the world already owes a debt of perpetual gratitude has recently offered to the profession a new tuberculin. He has clearly and minutely explained every step in its preparation, and he very properly proposes, instead of permitting Tom, Dick and Harry to destroy its usefulness and his own good name, that it shall be correctly prepared under his personal supervision by certain eminent chemists. For this grievous sin these medical pharisees cry out in holy horror: "Koch & Co."

Surely there must be a Zulu in the jungle!

Possibly some extensive drug and serum producers are not averse to continue reaping great profits, as they have in the past, from medical brains which are seldom, if ever, paid for, except perhaps by an occasional unremunerative "thank you." What wonder is it that they and their satellites are deeply offended and morally shocked when one of the ablest medical men of the age presumes to ask for a slice of his own bread. For this heinous crime they infamously endeavor to associate his glorious name with the lowest of patent medicine venders.

After what Pasteur, Koch, Behring and the forgotten isopathists have done for us we should hiss down such surly thanklessness and teach these cavaliers that such "ingratitude is treason to mankind."

If our desire to benefit the sick is earnest, and this new tuberculin is proved to be valuable, let medical men unite to persuade the central government at Washington, or their individual States, to award several hundred thousand dollars to Koch for the free use of his tuberculin for the benefit of Americans who are too poor to pay for it.

Why should we permit our sick to depend upon the almost boundless charity of the German Empire, which so generously rewards brains to sustain science, while our own Government does comparatively little for science or art?

COLLEGES OF THE FUTURE.

Were it not for most ignoble jealousies and prejudices the united strength of physicians and others of all schools could induce our national Congress to establish one of the grandest homes for the sciences that was ever founded by man.

Such an institution, perfectly equipped for laboratory and other scientific work, can, by the strong inducement of princely salaries, gather from various parts of this and other countries a magnificent concourse of talent.

A COLLEGE OF PROFESSORS.

Therein may also be established a "College of Professors," where physicians, surgeons and others who aspire to professorships may, after some stated term of practical medical or other experience, undergo severe ordeals in laboratory and other work, according to their intended future duties, before being allowed to present themselves as candidates for medical, surgical or other scientific professorships.

Exceptions, of course, should be made for the benefit of those rare geniuses who, while possessing valuable and peculiar ability in one direction, are of but small capacity in others. Such as these may be appointed to act as special teachers in their individual work.

It will be necessary that the living and all other expenses shall be defrayed by the States or National Government for those whose qualifications entitle them to admission.

There should be a careful yearly elimination of deficient persons, and transference to departments best suited to the capacity of each student. By such means only can we ever hope to crush out nepotism and general favoritism, which now exclude invaluable talent from all schools.

There should also be departments in this educational centre wherein every thought or idea which has any

possible therapeutic or other value will be respectfully and conscientiously considered, however humble its origin. There no timid thought nor once despised idea will be sneered at and then fondly embraced as one long honored and dearly loved, as has been the amazing history of the principles involved in antitoxins.

It will also be the duty of the "College of Professors" to decide as to whom honor shall be given for new discoveries or the development and rehabilitation of old or neglected useful ideas.

Upon such persons will be conferred diplomas and medals announcing their right and title to especial distinction. This will tend to diminish the temptation to hide profitable discoveries, as a very large proportion of scientific men are willing to sacrifice profit for honor, when honor is assured.

Such honorable distinctions may be first declared upon certificates of right of priority or other claims, and later, after the claims have been successfully defended and sustained for a specified period, then the final or grand diploma shall be publicly conferred, and the recipient at the same time decorated with the great medal of the legion of medical benefactors.

Those thus honored for their restoration of what is sound in ancient medicine, or for the development of original medical or surgical ideas, may bear the distinguishing title of M. R. D. (Medicinal Redintegratae Doctor), and words similar to the following inscribed upon their diplomas: "Qui sanas veterum dui oblivioni datas redintegravit, novasque ad homines sanandas vias ipse stravit."*

*Note.—Who restored the sound ideas of the ancients which had been for a long time consigned to oblivion, and who himself paved new ways for healing mankind.

For, after all, very many of the so-called new ideas are but a rejuvenation of the old.

There was prophesied in a former paper the probable future division of the profession, the surgeon being taught in specially instituted colleges of surgery and the physician in schools devoted wholly to medi-

cine, the diplomas distinctly declaring each specialty. Then neither may encroach upon the domain of the other, but both degrees may be held and used by any person who has time and ability to earn them.

Favoritism will doubtless continue to be cultivated in many institutions, but the future will apply every possible safeguard to prevent its rank growth.

The "College of Professors" may, in the coming century, be empowered through the Government or the generosity of individuals to offer most tempting prizes for the best hygienic or therapeutic suggestions or the ablest papers on various medical and surgical subjects. Some of these prizes, amounting to small fortunes, will wonderfully stimulate endeavor all over the country and throughout the world.

The most neglected and apparently trifling subjects will be named for consideration, such, for instance, as the medical ideas and instincts of the savage tribes in all countries, also the remedial instincts of the higher and lower animals, down to reptiles, insects and even lower animal life.

In those coming days it may not be so necessary as in the near past and present, to resort to the daily press to awaken physicians' comatose recognition of old and new truths.

These suggestions are not altogether Utopian, although selfishness and other moral infirmities of human nature may thwart many bright prospects in future years, even as they have in the past.

THERAPEUTIC SYSTEMS OF THE FUTURE.

While anticipating the future by viewing the past in the light of the present, we are struck by the peculiar and often unaccountable undulations of medical opinion. The rise and fall of confidence in systems, men and isolated medical ideas have increased in frequency in proportion to the rapidity of human intercourse.

Elimination as a practical idea has better withstood the storms of ages than any other medical thought, and it has sailed in safety amid the wrecks of thousands of strange fads,

good ideas and peculiar systems of practice. The plain, matter-of-fact idea of "get it out" has always appealed to common sense, and has had even more followers than that stern one of "keep it out" or prevention.

To the support of this golden rule of elimination, more than to any other precept from the profound wisdom of its learned legions, the great catholic, or, as sometimes called, physiological, school owes its continued existence. Scorning it lost for the school of similars many hundreds of thousands of converts.

Old Doctor Francis, of New York, once humorously said: "My name may not go down to posterity for anything in the arts, sciences or literature that I have accomplished, but as long as men have bowels I shall be remembered through my Triplex Pill."

VENESECTION.

First among the great eliminators were the emetics, cathartics, diaphoretics, diuretics and venesection.

Times were when the lancet was raised on high and the whole medical world knelt in adoration. Blood letting was once so deeply imbedded in the confidence of physicians that those who had the temerity to oppose it were treated as charlatans who were too contemptible to associate with respectable practitioners. But the lancet's enemies steadily increased in numbers until the rush in the opposite direction became one universal rout. While many thousands of lives were jeopardized and even destroyed by excessive use of the lancet, there may have also been other thousands which were sacrificed by its absolute neglect.

The future physician will return to the lancet of our forefathers, but not with their careless cure-all blood-letting. By the results of a more intelligent use of this potent remedy future practice will censure our uncompromising antagonism to the extraction of blood.

While it is true that aconite, veratrum viride, the nitrites and many other remedies, assisted by the accurate application of heat and cold, have efficiently supplanted bleeding in many congestive, inflammatory,

spasmodic and other conditions, yet serious cases have arisen where a sufficiently prompt relief could be effected by venesection only.

There are also certain grave conditions wherein the blood is so saturated with poisonous gases or other intoxicants that life would be jeopardized unless quick resort were made to full bleeding and at the same time replacing the diminished volume of blood by rectal and intravenous injections of saline and other solutions. Future physicians, fortified by more exact knowledge of guiding principles, will accurately determine what are proper cases and more skillfully apply to them this most potent remedy.

Of other eliminators the emetics and purgatives may, in a great measure be substituted by more mechanical measures.

Diuretics and diaphoretics, although remaining in the medical armamentarium, may be less freely used, but like all other means, will be applied with infinitely more precision than ever before. But this is to be discussed when special remedies are taken up.

ASEPSIS AND ANTISEPTICS.

Aseptic and antiseptic treatment will be necessarily more thoroughly understood and efficiently applied than in our day. Some of the simplest of ancient antiseptic or disinfecting substances, which we too generally ignore, will in the future be greatly improved and made invaluable to mankind.

CHARCOAL AND SULPHUR.

Very prominent among these stand charcoal and sulphur. Although many imagine that there is nothing more of importance to learn about these two simples, yet the coming century will undoubtedly prove that they deserve a far higher place than we have ever accorded them.

The ancients named sulphur the "godlike," and after an earnest study of this precious drug we, too, may possibly sanction this hallowed name.

When we think of the almost eternal endurance of charcoal, as evidenced by the perfectly preserved charred stakes, taken from the

Thames, which had been driven there by the invading Romans, we may well consider charcoal a fitting companion for the godlike sulphur.

Although theoretically knowing many things about charcoal, yet practically we treat it as a very ordinary and useless affair. If its merits were more carefully examined we would be amazed that it has been so long neglected. The future will place it in a higher position than it has ever held before.

Considering its immense capacity for absorbing gases, it seems strange that physicians have so seldom taken advantage of this invaluable quality of vegetable charcoal.

There are very few, if any, gases that it does not absorb under proper conditions, in quantities varying from moderate to immense amounts, especially when the charcoal is pulverized.

When thinking earnestly of this fact it seems safe to prophesy that in future years the shelves of our pharmacies will be black with innumerable preparations of charcoal impregnated with a long series of gases. To-day we seldom see more than one or two lonely jars of burned willow stick or powdered charcoal.

When physicians realize the dangers, as well as the benefits, of carbogigitalis they will not be apt to let their patients supply themselves from the coal bins of plumbers or tinsmiths. In such places its porous body drinks in and retains any foul air present, unless there is sufficient oxygen previously absorbed to neutralize such poisonous gases, and this diminishes the charcoal's future disinfecting power.

Vegetable charcoal freed from oxygen decidedly promotes putrefaction. Flesh or fish placed in such charcoal will decay much more quickly than when exposed without it. Deoxidation may be affected by bringing powdered charcoal to a red heat and then excluding it from the air so that fresh oxygen cannot enter.

Charcoal may also be deoxidized by placing it in alcohol; the oxygen leaves the pores of the charcoal and the alcohol is oxidized to acetic acid.

In the future this purifying qual-

ity in deoxidized charcoal may be taken advantage of in certain serious ulcerations, where, as long as any malignant tissue remains it is desirable to promote speedy and, if possible, painless decay.

In order to be able better to judge its probable future applications let us examine the known qualities of charcoal. As we have seen it has no disinfecting power in itself, but acquires it by condensing in its pores oxygen from the air and modifying it to a state of ozone.

If wet for any length of time charcoal loses its value, which can be restored only by drying and bringing to a red heat and again exposing it to the air.

Its power to absorb oxygen and other gases may be very greatly increased by boiling powdered charcoal in a solution of proto- or bichloride of platinum, then firing, as before mentioned, the platinum being decomposed and precipitated in a finely divided form, plates every minute particle of the charcoal, thus enormously increasing the surfaces and intensifying its action in condensing gases.

Bear in mind that charcoal may become surcharged with deleterious gases, so it must not be handled carelessly, for more of such gases may enter its pores than the contained ozone can destroy; therefore under such conditions it may cause disease. This fact will be recalled later when its proper preparation is suggested.

Strong nitric acid slowly oxidizes it to carbonic acid gas. It can also be oxidized by the galvanic current in a solution of sulphuric acid, or potassic permanganate and water. It remains unchanged, at ordinary temperatures, for all ages.

Let us now consider the probable uses which our medical posterity will make of the vegetable and animal charcoals, as well as their manner of preparing them for application and administration in disease. All forms and combinations of this valuable menstruum and medicament will be handled with the same care that is now exercised in preparing aseptic and antiseptic dressings, and as thoroughly protected from all

possible contamination from external sources.

Innumerable volatile substances which vaporize at ordinary temperature will be housed within charcoal, both for convenience of application and in some cases to intensify or change their action, as is seen in its effect upon oxygen.

The fact that there is a vast difference in the proportion of the various gases absorbed has to be taken into account. Ninety times its volume of ammoniacal gas enters its pores, and between nine and ten of oxygen, while much less than twice its volume of hydrogen gas is absorbed by charcoal. The amount will be estimated in every instance, especially those vapors from volatile substances, which may vary largely; and as every drug of this class is likely to be combined for internal as well as external use, most careful studies must be made as to quantity absorbed, as well as the increase or decrease of intensity caused, by each drug's association with the charcoal. It is probable that the vapors of turpentine will be changed within the pores. As every known volatile medicament, and possibly large numbers of those which do not give off these vapors, will be used, it would be impossible to record them.

In a general way we may name the fumes or vapors of creosote, phenol, naphtha, camphor, easily vaporized essential oils which have any known therapeutic value, ammonia, bromine, chlorine, iodine, phlorine, sulphurous acid, carbonic acid, sulphide of hydrogen and many other gases.

To obtain these various medicinal combinations the vegetable coal, as heretofore stated, must be brought to a red heat and then the coal must be kept in *vacuo*, and when cooled the gases may be forced within the containing vessel.

Jars holding medicated or deoxidized charcoal must be perfectly sealed to prevent oxidation of contents. There may be intestinal conditions where the deoxidized charcoal may be administered internally.

Multitudes of indications for such combinations will appear, especially when the value of external applica-

tions is fully appreciated. In some cases, where there is serious objection to the color, feeble gas absorbing substitutes may be found in some of the clays.

It is impossible to enumerate the conditions where, in its crude form and dynamized condition, charcoal and its combinations may be used internally and externally.

Now let us view charcoal as we know it in its simple form, as a medicine per se. It is singular that its real merits are so little known even to those who use its most delicate preparations. It may be so finely subdivided by prolonged trituration that its particles can enter freely even where the blood corpuscles cannot pass.

Some persons are so exceedingly sensitive to certain drugs that severe symptoms are at times produced by inappreciable quantities. During the war our old professor of *materia medica* in the Medical College of Virginia used to relate as an example his own exquisite sensitiveness to ipecac. He could not enter a pharmacy where, although unknown to him, anyone happened at the moment to be dispensing ipecac but that he was made aware of it by an asthmatic attack more or less severe.

After the drug diffuses itself through the atmosphere of a room it seems to lose the suffocating propensity sometimes observed in a freshly opened bottle. This same peculiar sensitiveness to drug action has been observed by some while taking purely powdered charcoal, and as it has affected many persons who were unaware of its behavior, it is folly to look upon all such manifestations as imagination.

A surgeon in the German army administered internally a few doses of charcoal, which had been very finely ground with sugar of milk, to a soldier who had typhoid fever. Soon there appeared a sensation of coldness, especially of the hands and feet, which ceased when the charcoal was withdrawn. The same symptom has appeared sufficiently often to be justly considered a result of drug action. Yet this peculiar chilliness has also been relieved by charcoal when it has appeared in the

course of disease. The fact that it does not benefit all such cases does not prove that it benefits none.

The future may find reasons and remedies for this supersensitiveness of certain individuals to drug, atmospheric, local and personal influences.

Among a very long list of symptoms produced or relieved, in persons sensitive to its action, in minute quantities finely comminuted with sugar of milk, are looseness or aching of the teeth, sensitive and bleeding gums, at times profuse; hemoptysis and epistaxis, occasionally periodic in their return; therefore it would seem indicated in intermittent affections, with or without fever.

Thoroughly triturated in combination with quinine, in the future it may be used to enhance quinine's antiperiodic effect and at the same time mitigate some of its unpleasant symptoms.

In delicate triturations it has caused and benefited flatulent distension of the abdomen even better than when large doses of the crude drug were used. Hoarseness and even aphonia have often been improved under its use. Certain forms of blood stasis have been both caused and relieved by triturated charcoal; also painful swelling of the lymphatic glands, especially the cervical. But this effect on the glands is more marked under the action of animal charcoal. Those who are most influenced by charcoal are persons of lymphatic constitution, aged asthmatics, persons of low vitality or debilitated by exhausting diseases. These are but a very small part of the conditions where it may have a remedial action when used in its dynamized form.

It has also proved of value in counteracting the effects of tainted meat or fish, rancid fats and conditions developed by salt meats, first, by its chemical and absorbing qualities in its crude form; then by its more delicate action upon the lymphatic and other systems, which are observed only under the use of triturations.

Of the immense number of striking symptoms recorded as having

been produced by charcoal, there are many which the more careful and thorough provings of the future may drop from the list. How studies of the *materia medica* may be conducted in coming years will be suggested in a later paper of this series.

As its receptive power is great and its particles so well adapted to assist sugar of milk in comminuting various vegetable and mineral drugs, it will assuredly be extensively used in the preparation of medicines. Volatile medicaments would be retained among the atoms of charcoal far better than in the commonly preferred milk sugar, but a combination of both would prove more desirable in preparing drugs containing such volatile matter. Probably the remedial power of many drugs would be better retained in such a menstruum. In some cases the first trituration might be made wholly with charcoal and then the finer preparations continued from this with pure sugar of milk. The following experiment can be tried by anyone: Take one part each of animal charcoal, vegetable charcoal and sulphur (or in correct proportions other remedies may be used, such as arsenic, mercury, iron, quinine or any other medicament); then add 30 to 50 parts of sugar of milk. Grind these thoroughly together in as large a mortar as convenient 15 or 20 minutes at intervals, as time and strength will permit, until this trituration has continued for three to six hours, or even more.

Take care that this is done in a room free from contaminating gases. Do not leave the powder exposed to dust, and when finished keep it in tightly corked bottles. As an alternative resolvent and antiseptic the sulphur combination will have an extensive value.

Another condition is developed by prolonged trituration, which will be considered later.

Of such triturations it is not well to use ordinary doses, for it should be remembered that this prolonged pulverizing intensifies drug action by making absorption far more rapid. It may be found necessary to add a great deal more milk sugar

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for sensitive persons. This plan of triturating with charcoal and sugar of milk can be extended to many drugs in common use, remembering always that in a few persons some of the peculiar symptoms of the charcoal itself may be witnessed.

It may be preferable, for the absorption of gases or for triturating with various volatile and other drugs, in order to avoid what is considered drug action, to use pure car-

bon from burned oil, which serves a better purpose. To obtain its medicinal action it is better to use ordinary wood charcoal, containing, as it does, silica, potassa and other salts, which are probably important therapeutic factors.

As this article has been carried beyond its allotted space, animal charcoal and sulphur are left for the next paper.



NOTES ON SOME OF THE CLINICAL FEATURES OF TUMORS,
THEIR ANATOMICAL CHARACTERS, MORPHOLOGICAL ELE-
MENTS AND THEIR THERAPY, BY TENTATIVE, CONSTITU-
TIONAL OR RADICAL MEASURES.

BY THOMAS H. MANLEY, M. D.
NEW YORK.

THORACIC TUMORS.

THORACIC TUMORS, INVOLVING
THE WALLS OF THE THORACIC
CAGE AND ITS INTERIOR.

Exclusive of mammary growths in the female those resting on or involving the walls are comparatively rare.

The most common are fatty tumors, which are most frequently lodged in the subcutaneous tissues in the dorsal areas.

Sometimes we will encounter in the adult, over the upper thoracic zones, cystic formations, which periodically open, discharge, close in, to again, after varying intervals, reopen.

They possess many features in common with a "cold abscess or tubercular sinus, which has its origin in a deep-seated suppurating lymphatic gland or diseased bone. There are bronchial clefts, the inclosed Wolfian ducts of the fetal mesoderm being continuous with the mucous surface of the oesophagus, the trachea or endothelia of the pleural surfaces.

A singular clinical peculiarity about them is that they seldom appear anywhere until after puberty.

One of the most valuable aids in the diagnosis of them is a microscopical analysis of their secretions.

By this means, with the aid of cultures, or inoculations if necessary, we may readily determine the specific character of the bacterial elements, and trace their histological cells to their source. This was well illustrated in a case which came under my care at the West Side German Dispensary in January of this year.

Just above and to the inner side of the breast and the outer side of the nipple of the left breast was a large fungating mass, periodically discharging an ichorous and purulent material.

The patient was a man past 50, who had been a soldier with the French army in Algiers. About a year after he left the service he began to complain of pains in the left intraclavicular region, extending downward toward the nipple.

Some months after this he noticed a small lump under the integument, which later inflamed and opened.

When he came under our notice the centre of the sore was raised and then extended in a circular direction, a stellated series of scar-like lines, fading away as they extended outward.

He had some cough and darting pains extending through thorax backward, especially when he made

any severe muscular effort or used the left arm. Physical signs pointed to involvement of the left lung.

This case presented many very complex features. He came of a tubercular family; he had had syphilis, and gave a history of sustaining a severe fall on the left shoulder on board a ship. The intermittency of the discharge, with probable connection with the respiratory apparatus, led to the suspicion of a cleft.

The gross appearance of the ulcer, with many other features of the case, inclined me to regard the case as one of actinomycosis. In order to decide the question three separate examinations of the discharges were made, when actinomyces in large numbers were found.

The case was now vigorously treated by the iodides and arsenic.

A saturated solution of iodide of potash was injected immediately into the mass and administered freely simultaneously internally with arsenic. Recovery has been complete and permanent. All the inflammatory hyperplasia has cleared up, all tumification disappeared and clean union of the parts secured.

His general health is re-established and once more he is able to work every day at his trade of a carpenter.

In this class of cases exact diagnosis is the key to successful treatment, with few exceptions. Closely allied to this type of neoplasm, though of an altogether different class, is another of an infectious origin, of common occurrence and always easily recognized. This carbuncle, which, though oftenest met with over the cervical vertebrae, is not infrequently lodged on either

side of the spinal wall of the thorax.

Carbuncle is not classified with tumors because its development is not attended with the presence of new histological elements, as its evolution is attended only with turgescence, hyperplasia, suppuration, sloughing, loss of substance and cicatrization.

But if infection by any of the fissile fungi is entitled to a place among tumors, so does that dependent on the streptococci, as anthrax.

My purpose in introducing it here is not so much with a view of enlarging the already numerous list of new growths as to introduce a practical point in the therapy of carbuncle, which, when it pursues an uninterrupted course, is always a painful affection, and sometimes even dangerous to life.

At first a carbuncle begins by a papillary inflammation of a very limited area, but with time it gradually expands, becomes hard, hot and painful, when central suppuration and sloughing begins.

At this stage constitutional changes are manifest, there is a tendency to the pyemic state. If now, circumstances permitting, the furuncle be deeply scarified or excoriated local and constitutional symptoms abate and the work of repair begins.

But we have the means of aborting these terribly painful masses in every instance if applied early, and dispensing with any mutilating operation in all.

This is all the the more acceptable because it dispenses with the need of anesthetics, cuts short the course of the malady and may be safely utilized by any practitioner.



Society Reports.

OBSTETRICAL SOCIETY OF CINCINNATI.

OFFICIAL REPORT OF MEETING OF JANUARY 21, 1897.

The President, Rufus B. Hall, M. D., in the Chair.

E. S. McKee, M. D., Secretary.

PRESENTATION OF SPECIMENS.

Dr. Thad. A. Reamy—I present this dermoid, not that I suppose it presents in itself any very remarkable features; it has the characteristics of all dermoids. This bunch of hair is only about one-half the quantity that was in it. The tumor has not been critically examined as to the bone that is here, but there is no doubt about it being bone. There are some interesting features connected with the history of the case. Here are two cysts. Possibly there was but one, and this neck may have been made by the adhesions. The tumor was removed last Saturday from a patient aged 58 years, the mother of several children. The last child was born 16 years ago, and the tumor attained, according to the patient's statement, two-thirds of the size it was when I operated on her about 14 years ago. The tumor commenced to develop 15 years ago, growing slowly, and nothing was done for it until the patient went under treatment about a year ago, and about six months ago the case was placed in the charge of a gentleman who, according to the statement of the patient, had a hospital and treated the case by electricity and various other means, and who tapped it five times within the last six months. It was tapped twice within the last six weeks prior to the time the patient came under my charge. A very interesting feature about the case, so far as the ethics go, is that at the last tapping the physician obtained a tuft of hair which, under ordinary circum-

stances, would have been sufficient to indicate to the operator that at least it was not a tumor that could be dispersed by massage and electricity. The tumor was of the right ovary, but the meanest attachment I had to deal with was with the rectum. The tumor was also attached to the sigmoid flexure. It was with a great deal of difficulty I could dislodge the tumor, and there was considerable hemorrhage that I could not control by the ligatures. The pedicle was quite small. There was some oozing, which I controlled by putting in a little packing of iodoform gauze, which was brought out of the abdominal wound. The patient has had no temperature. I examined the stitches to-day, the fifth day, and there seems to be union everywhere. I removed the gauze early, because I felt the hemorrhage did not demand that it should remain and I did not want its interference with the union. It is rather unusual in my experience that a dermoid of that size should remain without developing further for 14 years. It is not marvelous that it should refill so quickly after being tapped.

Dr. Gustav Zinke—When did you remove the gauze?

Dr. Reamy—After 24 hours.

Dr. Zinke—Did you find any adhesion?

Dr. Reamy—Only to the sheath of the gauze. My object in removing the gauze so early was to avoid the danger of a hernia developing at the lower end of the wound. After pulling at the gauze for a long time, per-

haps 20 or 25 minutes, I began to twist it and then it came away very easily.

Specimen No. 2.—I present this specimen also for a special reason. The specimen I just exhibited is very natural in appearance, because it has been preserved in a 2 per cent. solution of formaldehyde in water. I have tried formaldehyde a number of times, and am certain you will never use alcohol after you have tried this agent. The specimen I now present to you was preserved in alcohol, and is shrunken about one-half. It is a multiple fibroma. This was one tumor and was lying under the bladder; the bladder was pushed up above it, and the woman has experienced a great deal of vesical tenesmus for several years. I saw her four years ago, and was going to operate upon her at that time, but she ran away from me. The patient suffered intense pain, so much so that she had acquired the opium habit to a certain extent.

Dr. Edwin Ricketts—Approximately, what would the tumor have weighed when you removed it?

Dr. Reamy—It was about as large as my two fists. I simply present it to state to you with what facility I removed it per vaginam. I think I could not have delivered this tumor, without probably dividing the uterus, without stretching the vagina and cutting the perineum. The patient had a very narrow and long vagina, and, although a married woman, she had never borne children. The patient was quite fleshy and robust. This tumor presented in front, pushed the bladder up and caused tenesmus. I could feel the tumor through the bladder when the bladder was empty. I divided the neck, as is usual, and opened it posteriorly and anteriorly, and divided this tumor with my scissors before I removed anything else, and then I removed one-half of it. I also would like to call attention to the fact, in addition to the statement as to the facility in removing the tumor, that this patient had been in the habit of taking opium whenever she suffered pain. I used clamps and the patient complained of intense pain about eight or ten hours after the

clamps were applied, and I gave her a full dose of morphia, one-quarter grain, repeating it in an hour, and the patient got a splendid sleep. I did not have to again use morphia until about five or six days after I removed the clamps, when the patient had severe pain and some temperature, and I again gave her one-quarter grain of morphia. I had no trouble with the bowels.

Specimen No. 3.—This ovary (I lost the other one) presents nothing peculiar. It is one of a pair of ovaries I removed from a patient from Lima eight days ago, who was in the habit of taking very large doses of opium—one-half grain. The patient was the mother of two children, and she had had for the last two or three years frightful dysmenorrhea, and has had repeated and typical attacks of hystero-epilepsy. The suffering and pain experienced by the patient had become so great that she required opium. After full consultation with her physician, Dr. Terwilliger, I decided the best thing to do was to remove the ovaries. I dilated the cervix, curetted the uterus thoroughly and packed with iodoform gauze. Then I removed the ovaries, continuing to give her the same dose of morphia that she had been taking. It is now eight days after the operation, and she goes without the morphine. Yesterday she took no morphine at all. Of course, it is not anything new or novel that a patient in the habit of taking morphia should continue to do so after an abdominal section, but it is peculiar that two of us should have the same experience regarding the effect of this drug on the action of the bowels. In this case it did not affect the action of the bowels at all.

Specimen No. 4.—This was also a case of dysmenorrhea, lasting for a good many years. The patient was a woman, 25 years of age. It was a typical case of hystero-epilepsy. This woman was once, I think, in an institution of the State several years ago, but has had no trouble of that kind for a long time. For a great while the patient has clamored for the removal of her ovaries, but none of her friends would consent until

now. She had menorrhagia. She would menstruate eight or ten days at a time, and would almost have convulsions at the time. I found the cervix developed not quite in correspondence with the corpus. Yet the want of symmetrical development of the cervix was not sufficient to classify it as a typical case of infantile uterus. The patient commenced to menstruate at 13 years of age and continued to menstruate two years without pain. Those cases in which one part of the uterus is developed more than another are usually prenatal in origin. One ovary was more than double its proper size. This patient also had been in the habit of taking opium occasionally, but she was not an "opium eater." I found that the patient had intense headache on the second day after the operation. Her face became greatly flushed and her headache was perfectly terrific, and the pulse became a little irritable, so I was somewhat alarmed as to the symptoms. I gave the patient 40 grains of the iodide of potassium, and four or five hours afterward the symptoms had subsided. The patient took the second dose of iodide of potassium, but she did not take morphine.

In the case of the patient from Lima, when I gave her the first dose of morphine the pulse was irregular, about 120, but the temperature was not up, and half an hour after the dose of morphia was taken the pulse was down to 80.

I may say that I have adopted a little different method of dealing with the bowels. On the day of operation, before the operation is done, I am in the habit of giving the patient calomel, six to ten grains, and the next morning I give them a glass of Apeata water, and I seldom have to repeat it. If the operation is done in the afternoon, for instance, I give the calomel on the tongue about 9 o'clock of the same day.

PRESENTATION OF SPECIMEN.

Dr. L. S. Coulter—I will not take much of your time in presenting this specimen. You will notice a marked deformity, both at the upper and lower extremities, clubbed feet and

clubbed hands, and the limbs, the right arm and the right leg, show fracture which must have occurred intra-uterine, because there was no instrumental interference on my part, and I noticed these fractures immediately after delivery. The child was born breech first, and there was a little difficulty in delivering the head, but not as much as we often encounter. There was a condition of hydramnios, and I never before attended a woman in which the amount of liquor amnii was as great as in this case. Before delivering the abdomen was prominent, large and a globular shape. Upon examination it was almost impossible to make out the fetal parts. Before the membranes were ruptured I could not detect anything like the head or breech of the child. After the membranes had ruptured the breech presented and the child was soon delivered.

PRESENTATION OF SPECIMEN.

Dr. Magnus A. Tate—I want to present a small specimen of the urine of a patient I delivered recently. The patient was a light mulatto, about 22 years of age, with a syphilitic taint. Yesterday she scrubbed the floor and had been working regularly every day up to that time. This morning about 7 o'clock she began to complain of a terrific headache, and about 8 o'clock she became unconscious. I saw her about 10 o'clock, and I immediately inserted the catheter and drew off about a teaspoonful and a half of urine, which was very dark, mostly blood. The patient was about eight months pregnant. About half-past 10 or 11 o'clock she went into a comatose condition. The diagnosis was uremia, and I have brought this specimen of urine after having boiled it. The main feature is the amount of blood which it contains and how soluble it is. The history of the case I hope to present later on. I never before saw a case in which the urine presented this appearance, and, of course, another very interesting feature in this case is the short duration. I asked my friend, Dr. Rachford, to come to the hospital and draw off some of the blood so he could make a microscopical examina-

tion, and in the future I hope not only to present the full history of the case, but also to present his report. He said he had never seen such urine taken from a patient. As you will see, this specimen presents the appearance of meat.

PRESENTATION OF SPECIMENS.

Dr. J. Ambrose Johnston—I have here an ovarian tumor. The patient from whom it was removed had been suffering about six or eight months. She went to a dance and danced four or five hours, and after coming home suffered very considerably. I saw the case a week or two after the dance and I found the abdomen distended with ascitic fluid. I removed this tumor, whose pedicle presented a quarter turn. It had begun to degenerate, and caused perhaps three gallons of fluid to collect in the abdomen.

Specimen No. 2.—Here is a fibroid tumor from the cervix uteri. This tumor was attached by a small pedicle near the os. The tumor was entirely extruded from the uterus. The cervix was drawn around the small pedicle, which I snipped off with a pair of scissors. As you will observe, the pedicle is only about one-fourth of an inch long, and yet the tumor was completely extruded from the uterus.

CASE REPORT.

Dr. E. Gustav Zinke—About a month ago a lady upon whom I performed an ovariotomy three years ago was brought to me from Indiana by Dr. Peterson. The patient is about 46 years of age, and in appearance perfectly healthy, but her stature had changed, so that when standing or walking she presented a picture a good deal like that of a subject in the first stage of hip-joint disease. About a year before I saw the patient she had fallen upon the pavement, striking upon the left gluteal region. She got up and after a few days the soreness subsided. The patient noticed no inconvenience from the injury until three or four months later, when she began to complain of what appeared to be sciatica. From the letters I received at the time from the doctor I could only confirm the diagnosis. I did not see the pa-

tient at that time. No matter, however, what was done for the sciatica, the pain continued, and by and by pretty large doses of opium or morphia had to be administered to give the patient relief. Her general health did not suffer, but she could not move without causing great pain; in fact, she was brought here on a cot. On digital examination I could find nothing. On inspection I could only detect the deformity we are accustomed to see in *morbus coxaris*. But when I had the patient stand up I found the right buttock considerably lower than the left, and there was a distinct fluctuation to be ascertained by palpation. The left gluteal region also appeared somewhat swollen. The right gluteal region was about two inches lower than the left, and the gluteal fold had been completely obliterated. I then put the patient in the lithotomy posture, when, to my surprise, I found the swelling had all disappeared. Even under the influence of chloroform neither Dr. Evans, who was at the hospital at the time, nor myself could detect anything. The next day I again examined the patient upon her feet, and found the same condition as before. Whenever she got into the upright posture there appeared to be fluid present, but when she resumed the recumbent posture it disappeared. I kept the patient in bed about two weeks, and the pain subsided, so there was no necessity of administering any drug for the relief of pain. She then became anxious to go home; but before she went I had Professor Conner examine the case. He made a very careful examination. He examined her also through the rectum, which had been emptied for the purpose, and suddenly his attention appeared to be attracted by something. After a careful examination he asked me to examine the same region. Here we found a small tumor about the size of an ordinary pear, with a pedicle springing from the right sacro-iliac synchondrosis, and extending over the right sacro-sciatic foramen. It was apparently a hard, firm tumor, solidly fixed in that region. Then I asked Professor Conner how he would explain the sense

of fluctuation and the disappearance of fluid when the patient was in the upright posture. I had before expressed the opinion that possibly it was a hernia through the sacro-sciatic foramen. We finally concluded to operate. Knowing the dangers of the region in which the tumor appeared to be, and the large blood-vessels and nerves surrounding it, I was not anxious to operate, and was very glad when Dr. Conner offered to do the work. Before he proceeded to operate he thrust his finger again into the rectum, and I noticed the same change come over his countenance that I observed when he examined the patient for the first time. I asked him if he found anything else, and he said no, but he could not find what he found the first time. The tumor had entirely disappeared. Of course, the operation was not made. In the course of two weeks thereafter the patient left for home, and she is still comfortable, but the same condition exists. I thought that probably by presenting this obscure case some of you might be able to shed some light upon it.

What is your diagnosis?

Dr. Zinke—I thought it might be a condition resulting from an operation, in which possibly an opening was made in the broad ligament and covered by the peritoneum proper, and that a hernia formed, and the fluid we feel is merely peritoneal fluid, and the tumor was nothing but a mass of feces kept there in the loop of bowel that had found its way into the hernia when we made the examination. There evidently is no pus present, although Dr. Peterson, when making an examination with a bivalve vaginal speculum, said he gathered about a tablespoonful of pus, and at that time it was thought possible there was some opening there. But there was no discharge of pus from the vagina while the patient was under my observance, and an examination of the vagina failed to reveal any opening.

Dr. A. W. Johnstone—Does the appearance of the fluid, or whatever it may be, in the gluteal region always give pain?

Dr. Zinke—No.

Dr. Johnstone—What is the muscular reaction?

Dr. Zinke—It is good. When the patient is upon her feet this all becomes exceedingly cyanotic, blue in appearance, which I believe is due to the impediment of the circulation by the fluid. She has fluid there now, but you cannot find any fluid when she is in the recumbent posture.

Dr. Reamy—Is the mass most in front or behind the uterus?

Dr. Zinke—It is behind the uterus. The mass seems to fill the posterior cul-de-sac, the right entirely and the left partly.

Dr. Reamy—You could make a diagnosis by simply cutting in behind the uterus and carrying your fingers in and finding what it is.

Dr. Zinke—How about an abdominal section?

Dr. Reamy—Oh, don't do that; that is more dangerous.

Dr. Zinke—But if you should do an abdominal section you could relieve whatever you might find.

Dr. Reamy—But you could do as I said for the purpose of diagnosis without practically any danger.

Dr. Zinke—I aspirated, but could not withdraw any fluid except blood.

DISCUSSION.

Dr. Johnstone—The case Dr. Zinke has reported is to me by all odds the most interesting I have heard for a long time. There are several things that are possible. I have been sitting here thinking of an exploratory incision I made at one time. A woman was apparently dying, and I thought there was a cancer in the position he has described. The patient was progressively running down, and as a last resort I made an exploratory incision, when I came across the queerest condition I ever found in the abdomen. The head of the cecum was down in the pelvis and filled solid with feces. The mass was clear below the ileo-cecal valve, so there was absolutely no current to wash the feces out, and there they stayed. But this was not what caused the trouble, for in that case there was a sarcoma, which I could not diagnose from the outside. The last thing Dr. Zinke says about the case

—that is, the introduction of the aspirator without getting anything—shows it must be a venous congestion, probably due to something on the inside, causing interference with the return of the venous circulation. I know it is possible for the cecum to be very much dislocated. In the case I have mentioned there was a hard ball of feces, which seemed like bone upon examination through the vagina and rectum. That patient was bed-ridden when I first saw her, due to the pressure on the solar plexus. Whether or not it is the head of the cecum in the case reported I do not know; it might be a chondroma.

Dr. Zinke—If you were to put a knife between a drawer and the table and try it you would get the same springy sensation that was to be observed in this case.

Dr. Johnstone—Were I to make an incision there I would make it near the umbilicus. You must remember the sacro-sciatic notch is nearer the umbilicus than is the field where we ordinarily work. It is like the old operation that Tait used to make for the removal of tumors of the ovaries.

Of course, we have to give opium to cases such as have been described, but I never quit with them until I get them to stop it. I had the saddest case two years ago. One of the brightest and smartest women I ever saw, the wife of a physician, who married her knowing she was an opium-eater, came to me with infantile uterus and cystic ovaries. They insisted on me operating while the patient continued taking opium. I refused to do so, because I knew of several cases that had been pulled through operations without stopping the habit, and several of them had been broken of the opium habit and recovered from both. The husband took the patient away after bringing her two or three times. Each time she had thought she could fool me, but she found she could not, and at last she went back home. The last thing I told the husband was to not let the patient be touched with a knife until the opium habit was thoroughly broken up, or the opium habit would continue all her life. It was not six months until an opera-

tion was done, and there she stayed for a year or two, and she finally died from the complications of opium-eating. That may be a unique experience, but I have never seen a patient operated upon, without breaking the opium habit first, who ever got over the opium habit afterward. So I would never operate upon one of these patients before they stopped the use of opium, unless it was absolutely necessary to do so in order to save life. Every pain they have ever had, every backache that has ever existed, every headache, is not modified in the least and they go on using opium just the same as ever. But where it is a case of life or death, of course it would be perfectly justifiable to operate while the patient was keeping up the use of opium. I have a case now in which the patient is taking morphine regularly. It was a case of carcinoma in which I found the internal iliacs were involved and there was such a condition present I could not make a complete operation. I found a number of little warty growths. In that case there was no difficulty whatever in getting the patient's bowels moved, because in these cases, as a rule, when you begin to break off the opium the bowels become loose. What I dread is giving morphine to patients not accustomed to it.

Dr. Giles S. Mitchell—Dr. Johnstone's experience is absolutely at variance with my own. During the past 15 years I have treated many cases of opium habit, but with unsatisfactory results; indeed, the only case I have ever succeeded in curing was a lady patient who contracted the habit by taking morphine to relieve the pains of dysmenorrhea. She had been using morphine for five years. Daily average, one and a half grains simultaneously. Both ovaries were removed, and when the patient was able to leave the hospital she was cured of both dysmenorrhea and morphia habit. My recollection is that the aggregate of morphine taken after the operation would not amount to more than eight grains. I readily appreciate, as Dr. Johnstone has said, that after the morphine habit is formed it is

next to impossible to differentiate between the pain incident to the withdrawal of the narcotic and the original suffering. But it impresses me that the most rational procedure is first to remove the cause of the vaginal pain and then withdraw the morphine.

As to the case reported by Dr. Zinke, a diagnosis is impossible without an exploratory incision.

Dr. Charles L. Bonifield—In discussing the question of continuing opium in operative cases I simply want to report the case of a woman who had been accustomed to taking morphine for 40 years. After the operation, of course, we continued to give her opium, at first in the form she had taken it and afterward we gave usually gr. jss of morphia at a dose. We succeeded in diminishing the quantity quite materially by the time the patient left.

In the last year it has been the custom of myself—and I think of Dr. Withrow—in almost all cases which we had to pack with gauze to make the opening in the vagina and bring the gauze out that way. Gauze is not as good a drain as it is sometimes supposed to be, and if we can assist it by gravity it is a very great advantage. It has always been my custom to commence removing the gauze in about 24 hours. I simply lay the gauze in in regular folds, so that the end that comes out will not be tangled with any other part of the gauze. In this way I have never had any particular trouble in removing it.

Dr. Zinke—Dr. Reamy's case certainly brought up some very interesting points, not only with reference to cure of the morphine habit, but especially with reference to the use of gauze as a drainage. I know when gauze was first used for that purpose I always had trouble in removing it, and subsequently I had to leave the gauze in so long it absolutely separated by suppuration. The peritoneal cavity was then, of course, shut off, and I could cure my patients without a hernia. Now I use a drainage tube in the centre of the gauze, so the drainage tube is entirely shut off from the peritoneal cavity. Before I remove the drain-

age tube I remove the gauze, because the gauze is full of fluid, and by twisting it you render it dry and leave the very fluid in the cavity that you want to get out.

In reference to Dr. Johnstone's remarks as to the morphine habit, he either has not made himself understood to me or he and I differ radically in our views. These patients certainly cannot be so successfully cured of the opium or morphine habit before as after we remove the cause of the pain. I think in the case he refers to the case was not operated upon soon enough, and by the time she was operated upon the habit had become so established it could not be broken up. And even if the morphine habit had been broken up what assurance have we that she would not have landed in the insane asylum?

Dr. Johnstone—That patient was not insane, but went there to have the habit broken up.

Dr. Robert Stewart—There is only one thing I would like to call attention to, and that is the case of Dr. Colter's, which I think is of extreme interest from an obstetrical point of view. It looks to me like a case of infantile syphilis. It would be probably called a case of infantile or fetal rickets; probably it would be better classified as a case of infantile syphilis.

Dr. Colter—I could not get from either of the parents any history of syphilis.

Dr. Stewart—The head is very large and the bones are soft and broken, and the fractures would argue for the brittleness of the bones, and the epiphyses are enlarged, which would all speak for syphilis.

Dr. Edwin Ricketts—in regard to the use of opium I reported to this society the case of a lady suffering from ovarian tumor, who had used morphine for quite a time, and who after an ovariotomy was enabled to stop its use and never used it afterward. The case was reported to this society, and was afterward quoted in the British Medical Journal. I think there has not been enough said upon this point as to what we shall do with opium users.

The question is not settled by any means. A case of gall-stones was reported to this society a year ago this month, in which a gentleman had been in bed from August until December, and on the day of operation had to have seven grains of morphia. The operation was done and two stones removed. The physician in charge tells me that gentleman has been able to stop the use of the morphia entirely. On the other hand I have three cases of opium users in which I removed diseased appendages, and all three died. I think I am responsible for the death of those patients because I did not permit them to use opium right along as they had been using it; in fact, I had been deceived by two of them in that I did not know the real amount of morphine they had been using. I do not think Dr. Johnstone has given us sufficient reasons for speaking as he has this evening. I believe a greater percentage of these patients will do better if the operation is done while they are using the opium and the habit is broken up after the operation.

Dr. Rufus B. Hall—I do not care to discuss anything but the opium question. I am glad to hear the differences in opinion in reference to the use of opium and the effect of continuing and discontinuing it at the time of operation. I, like the rest of you, have given this subject especial attention, and am about convinced of the fact that patients who have used opium for a long time—over four, five or six years—and are accustomed to taking opium or morphine but once or twice a day, and especially where they have the usual one dose a day, it makes very little difference to them whether you stop the opium after the operation or before the operation; in fact, the opium seems to have no effect on the movement of the bowels afterward, which is what we most dread. But the acute cases, which must have several doses a day, I am always afraid to put through an operation; I am afraid of the immediate result, that they will die following the operation because you cannot get the bowels to move. And if you keep the opium from them they do not do well after-

ward. In other words, if I have a case that is acute and is taking from three to five or eight grains a day, and has only been taking it a year or less, if I can reduce the quantity to a quarter of a grain a day for a few weeks I do not feel so afraid of losing the case at the time of the operation. My views are well expressed by Dr. Giles Mitchell with reference to breaking these patients of the habit afterward. I have had two or three cases that I can recall now in which the patients tried hard to stop the opium habit before the operation and could not do it on account of the pain, but after the operation the habit was readily broken up without any difficulty. One patient I can recall now, the only daughter of a prominent family, a married woman 30 odd years of age, who had used opium five or six years. She had a small dermoid, not larger than a small orange, which apparently had existed all this time. The patient was taking several grains of morphine every day. She had been at institutions for a long time to get the habit broken, but in this was not successful. She took less than eight grains of morphine after the operation, now five or six years ago, and she has taken none since. Of course she has had the encouragement of her friends to help her discontinue the use of the drug. I cannot see how it could be possible in such a case to stop the morphine entirely while the patient was suffering the pain that demanded its use; but I believe in an acute case if we can reduce the quantity of morphine before the operation the chance of the patient for recovery is better, and I cannot understand why we could not break them of the habit after the operation as well if not better than before the operation.

Dr. Reamy—Before I forget it I wish to say to the gentlemen who referred to the gauze for drainage that they have a misconception of the reason for which this gauze was used. It was not used for drainage at all, it was used simply as a hemostatic to stop the oozing. The amount of blood which would be in the gauze would do no harm, and I took it out early because I knew it

would come out easier than than later.

As to Dr. Zinke's case, if he were to make an exploration and do nothing, except perhaps break up some adhesions, he could stitch it up and the woman in a few days would hardly know anything had been done. It is the easiest and safest operation imaginable.

Dr. Giles Mitchell—Do you mean to say you can sterilize the vagina thoroughly?

Dr. Reamy—Well, I do not know. If the doctor should find a growth he could remove it through the vagina as well as any other way, and if so desired he could leave the wound open for drainage.

As to operating upon patients who were in the habit of taking opium, in the course of the last ten years I have talked upon this subject more than upon any other subject. If my experience accorded with the experience Dr. Johnstone relates in the instances to which he has referred I would certainly take the same ground as he does; but his experience is so absolutely contradictory to my experience and the experience of those with whom I have conversed that I cannot be governed by his experience. I cannot stop now to go into cases, but those patients who continue the use of opium or morphine during the operation stand the operation better than those who do not, *coeteris paribus*.

In the last case I reported, as the doctors who are present will testify, the ovary was adherent and the intestines were adherent; the woman had had a peritonitis, and undoubtedly that accounted for the pain the patient had suffered. The case came under the head of Dr. Johnstone's inflammatory dysmenorrhea. I operated upon the woman for the relief of the conditions for which she was first induced to take the opium. She had no twisted pedicle, her life was not imperilled, she was not in worse condition than than she had been for two or three years, but the patient had such pain she could not stop the use of opium, so I continued to give her the opium. And then we took advantage of the removal of the

pathological conditions, which were the primary cause of the pain, and secondarily we took advantage of the woman's changed physiological condition and the fact she knew the operation was done for her cure and her knowledge that the cause was removed. We were thus able to get her to stop the opium habit. If you can get a patient to understand the situation and get her moral consent this is the time most favorable of all. Instead of the woman going on to ruin it is one of the highest prerogatives of good surgery and a glorious result that we may rescue these women from their formidable habit. And so I hope Dr. Johnstone's statement will not be heeded.

Dr. Johnstone—What proportion do you cure?

Dr. Reamy—I do not remember, but I can recall two cases that I have operated upon who had the opium habit and were broken of it after the operation.

Dr. Johnstone—Both those cases were operated upon when I was with you, and they were still taking opium when I last heard from them.

Dr. Reamy—Well, I do not know about that, but I can give you the name of one patient who has stopped the habit. I do not know how many cases I have seen, but the number is so large it causes an impression upon my mind to such an extent that it guides my practice. After operation is just the time to cure these patients, although the operation we know, of course, will not cure them of itself. There are two young ladies now down near Lexington, both of whom had hystero-epilepsy, and I saw them both in Lexington about a month ago. Both are perfect pictures of health and do not now take any opium.

The case of Dr. Zinke's, I would think, had malignant disease, if the fluid continues.

Dr. Zinke—She is otherwise in perfect health.

Dr. Reamy—Well, then, it might be an ovary or almost anything else. But the cecum is the most firmly bound down of any part of the gut, and I have seen only one case in which it protruded.



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SPECIALISM AND THE GENERAL PRACTITIONER.

Notwithstanding the rapid growth of specialism there remains a place, and ever will, for the general practitioner, the all-around man, who studies carefully the complete organism and carefully treats it and its component parts. The eye, the ear, the skin, the womb are all in his domain, and should be treated by him for their ordinary diseases. He should know enough to treat such cases properly and to recognize the cases that require the skill of the specialist. The specialist chosen had better be one well grounded in ordinary practice, and not the one-sided man who knows nothing outside of his specialty.

From appearances it would appear that specialism is becoming epidemic. Some believe that the general practitioner will become rarer every year, and finally extinct. But the law—the survival of the fittest—will find expression here, and the

new specialist, the young man who has entered upon his life work with but a scanty preparation and with an eye for the main chance, easy hours and profit, can hardly cope with his brother specialist who has worked up from the ranks after a severe course of general practice, which has enriched him with a wide experience, not alone of diseases in general, with their effects on special organs, but of human nature, in which school no one has precedence over the family doctor.

The point we would insist upon is this—specialists should be recruited from the ranks of general practitioners. Then specialism cannot prove mad.

The remarks made by Beverly Robinson at the last meeting of the Association of American Physicians (reported in Boston Med. and Surg. Journal just to hand) show the desirability of our contention. He

said: "The specialist should remember not to treat the nose and throat alone, but to look after the general condition of the patient. The great contrast between the general practitioner and the specialist in the treatment of diseases of the upper air tract was that one looked too much after the general health and

neglected local treatment, while the other paid too much attention to the local causes and forgot about the rest of the body."

We will add, the specialist who is well grounded in general practice is the ideal specialist, an ideal that has been and can be realized.

SURGERY FOR TYPHOID PERFORATIONS.

The advance of abdominal surgery is well shown by a paper in the Medical and Surgical Reporter, of Philadelphia, November 7, 1896, in which Dr. Joseph Price relates three cases of recovery following the closure of perforation of the bowels through typhoid ulcers. Of the third case he writes: "I never attempted to close a filthier peritoneal cavity than this, either ante mortem or post mortem."

Dr. Joseph Price urges that every case of perforation should be operated on, for surgery offers the only chance of recovery, although the mortality from such operations must always be high.

At the meeting of the Royal Medical and Surgical Society on January 26 of this year Dr. Lauder Brunton and Mr. Bowlby related a case in which symptoms of perforation of the intestine developed suddenly about a month after the patient was

convalescent from typhoid fever. About 18 hours after the first onset of pain the abdomen was opened, a perforation was found and closed by Lembert sutures, and the parts were thoroughly cleaned. Recovery took place, the patient regaining his normal weight in the course of a few months. It was stated that this was the third recorded case of the kind submitted to operation in this country, and the first successful one.

At the same meeting Dr. Herringham and Mr. Bowlby recorded another case in which the abdomen was opened owing to the occurrence of symptoms of perforation during the convalescence from typhoid fever, but in which no lesion was found. The patient recovered. This case was brought forward to show that in cases of recovery from supposed perforation without operation there may not really have been any perforation at all. This is a most important fact.

A CORRECTION.

We may have been somewhat hasty in our announcement that "Illinois close upon the heels of its bill to regulate the practice of medicine in that State has admitted the Osteopaths into all rights and privileges of full-fledged, educated physi-

sians" in our issue of May 21, but then we did not know Governor Tanner would veto the admittance of the latter class. We are glad we have one State in the Union whose Governor can veto bad bills and give rights to regular physicians not enjoyed by the quack.



GENERAL ELECTRIFICATION AS A RESTORATIVE TONIC.

The instinctive tendency of a patient seated upon the static platform is to take a deep breath and compose the nervous system to rest. With the deepening of respiration the force of the heart is energized and regulated, the internal and surface circulation is equalized, the general tone of the nervous and muscular systems is increased, combustion is carried forward, and increased appetite and capacity for digestion, exercise and sleep, together with a condition of physical refreshment, ensue upon repeated applications.

VAGINISMUS.

Apply vaginal bi-polar faradic sedation with the secondary induction coil selected to produce the most powerful constriction of the muscular fibres that comfortable tolerance permits. Maintain the full dosage for 15 minutes and reduce to zero very gradually. Repeat daily until relieved and continue three times a week until the condition is entirely removed. Improvement will be demonstrated after a very few treatments.

If the mucous membrane is hot and dry the bi-polar application restores the normal secretion.

OVARIAN NEURALGIAS.

Over these pains of women electric currents exercise a sovereign and beneficent sway. Warm and lubricate the improved bi-polar vaginal electrode and insert it into the cavity so that the positive tip rests

upon the site of greatest tenderness. Support it with very gentle pressure during treatment, switch into circuit the 1500 yard No. 36 coil, the rapid vibrator and four or five celis. Increase the current strength through the rheostat from zero to the point of comfortable tolerance, being careful to avoid directing the electrode so that the tip sends the current through the muscles of the thigh.

As sedation takes effect and the current becomes less perceptible again slightly increase the dosage. Maintain it at this point for about 15 minutes and very gradually reduce to zero.

Repeat the application daily for a few days and when relief extends to longer intervals lengthen the time between the sittings accordingly. When relief becomes satisfactory and progressive continue the sittings three times a week until complete health is restored.

As the diagnosis of the cause of pain cannot always be made with certainty we may suspect some graver lesion of the ovary if improvement does not progress and is not retarded by the patient's indiscretion or by known complications.

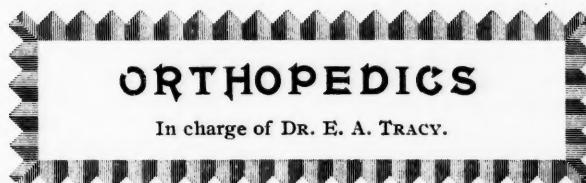
In any event vaginal bi-polar faradic sedation is the first remedy to employ for the relief of pain and the improvement of local nutrition. Treatment three times a week between menstrual periods will in a short time give relief to any uncomplicated case. If the ovary is hyperemic and drags heavily upon its supports the same method will give tone to the tissues, disperse the congested engorgement and, with the aid of a

carbolic and glycerin tampon after the withdrawal of the electrode, the patient will rapidly secure permanent comfort.

If some occasional pain returns after a reasonable number of bi-polar treatments place a felt-covered flat electrode, 6 by 9, over the lower abdomen on the side affected and connect it to the negative pole of the galvanic switchboard. Connect a cotton wrapped carbon ball electrode with the positive pole. Moisten it in a one or two per cent. hot water solution of bicarbonate of soda and insert it in the vagina in contact with the sensitive ovary.

Gradually increase the constant galvanic current from zero up to about 20 mil. Maintain this dosage for ten minutes and reduce to zero. Repeat three times a week.

By the use of one or both of these methods many of the painful ovarian disturbances may be treated with perfect confidence in the result. Unless a grave lesion is present to prevent its curative action there is nothing more practical and satisfactory in the whole range of medical gynecology than the action of high efficiency electrical currents in the treatment of neuroses and functional disturbances of the pelvic organs.



ORTHOPEDICS FOR THE GENERAL PRACTITIONER.

CHAPTER I.

BY EDWARD A. TRACY, M. D., BOSTON.

Fellow of the Massachusetts Medical Society.

Upon the general practitioner, who sees the various diseases of the different organs in their very incipiency, rests considerable responsibility. For the most part, at this stage of such troubles, recognition of the trouble and rightly applied efforts are sufficient for the cure. Such efforts, for several orthopedic diseases, are easily within the reach of the general practitioner and can well be made use of by him.

The family doctor ought to know enough to diagnose tubercular knee-joint disease, hip disease and Pott's disease of the spine. Their recognition in their very incipiency is most important. The treatment of these diseases in this stage is simple

enough, the essentials of it all being rest, as nearly absolute as possible, for the diseased parts and the highest attainable degree of health for the rest of the body. To the orthopedists is due all honor for the successful mastery (in great part) of these diseases, which have heretofore done so much damage to the race. However, there is a tendency to confuse by complicated apparatus the principles that govern the treatment of these cases. This tendency it will be our aim to dissipate. The correct principles of treatment will be insisted upon, the simplest method of applying these principles pointed out.

In this paper we shall treat briefly of the diagnosis of incipient hip-joint disease. This disease is apparently very acute in its onset, a lump suddenly manifesting itself, followed quickly by pain, frequently referred by the little sufferer to the knee. The writer has treated a case where the pain was referred to the lower lumbar region. The child quickly takes to bed, and great sensitiveness of the hip joint supervenes. The thigh is flexed, the foot everted and the limb thrown outward. The constancy with which pain is referred to the knee should not throw us off our guard and lead us into the mistake of thinking the knee to be the seat of the disease. An examination of the knee shows it to be normal, like its fellow, with no extra amount of fluid in the joint, no roughening of the membrane, no enlargement, no tenderness on pressure, no thickening of the synovial membrane, and nothing abnormal in the contour of the joint. (The knee should always be examined and watched, as the writer has treated tubercular knee-joint disease with hip disease on the same side in the same patient.)

The hip joint is generally found tender on deep pressure over the trachanter. "Night cries" are often present, due to muscular spasms, pulling sensitive joint surfaces together. Muscular rigidity is the chief diagnostic mark of hip-joint disease; because of this rigidity the normal motions of the hip joint are limited. This limitation of motion is due to tonic muscular contraction of the muscles acting upon the joint. This stiffness, to a more or less degree, is always present in hip-joint disease, and should be carefully sought for. Not that its detection is at all difficult in most cases, but sometimes in very young children, when the limitation of motion is but slight, it requires patience and tact to discover it. The movements of both hip joints should be compared carefully. In testing the amount of flexion of the suspected limb it is well to distinguish between actual flexion and apparent flexion. Sometimes the diseased limb can be apparently flexed as much as the sound

one, but if we take hold of the ilium we shall find that it is stationary during the motion of the sound limb, while on extreme flexion of the diseased limb it moves backward with the thigh, allowing the knee to approach as near the abdomen as the other one, though the actual flexion of the thigh is less. This is an important point. Limitation of extension can be discovered by pressing on the knee till the under surface of it touches the flat surface upon which the patient lies, when, if there is limitation present the back will be found arched up somewhat. Limitation of abduction or adduction can be noted by holding the pelvis and comparing the motions of the normal and the suspected limb, the pelvis moving with the limb when the limit of the joint's motion in these directions has been reached.

After a time atrophy of the thigh and leg muscles is noticeable, and the fold of the buttock over the diseased hip becomes obliterated. Of great importance is the gait, a limp, sometimes being more marked than at other times, being always present in hip disease. Lameness in a child should be carefully noted and its causes investigated.

The temperature has been found a degree or two above normal in several incipient cases treated by the writer. The most important point in the diagnosis of incipient hip-joint disease are:

1. Limitation of the normal joint motions.
2. Limp.
3. Leanness of the thigh and calf due to muscular atrophy.
4. Pain generally referred to the knee.
5. Tenderness on deep pressure over the great trochanter, or deep in over the head of the femur.
6. Temperature above normal.

The writer has seen several cases of sudden onset when several of these signs were present, and which naturally caused for the time apprehension of severe joint trouble. Nevertheless the symptoms disappeared in from two days to one month.

This shows that the diagnosis must not be made too soon. Watch

the case, treat it properly and reserve your diagnosis until the signs that distinguish the trouble are such that doubt need no longer be entertained. About the proper treatment we shall treat of in our next.

THE TREATMENT OF TUBERCULOUS DISEASE OF THE HIP IN ITS EARLY STAGES.

BY HOWARD MARSH, F. R. C. S.
Surgeon to St. Bartholomew's Hospital.
(Abstract from British Medical Journal,
May 8, 1897.)

In the British Medical Journal of April 24 is a paper by Mr. Tobin on "Osteotomy of the Femur as a Treatment for Tuberculous Hip Disease in its Early Stages." In the following remarks it will be my endeavor to show that the difficulties which have presented themselves to Mr. Tobin, and to meet which he has resorted to a proceeding the advisability of which I believe many will be inclined to question, have received the attention of surgeons both in England and in America, and have been overcome by methods that can readily be applied.

Large effusion in early tuberculous disease of those joints which are superficial enough to allow an investigation of this point—the hip, the knee and the ankle—is seldom present, and I am not aware of any evidence to prove that the hip differs from the other joints in this respect. The probability seems to be that the hip, like the other joints, is placed in the position of greatest ease, not because it is distended with fluid, but in order that the swollen and sensitive, soft structures may as far as possible be placed in a state of relaxation—one of the principal elements of physiological rest. The familiar experiment of Mr. Swann, which Mr. Tobin quotes, no doubt shows that the capsule can accommodate the greatest quantity of fluid when the limb is flexed, abducted and everted. But that the limb assumes this position in early disease is no evidence that the joint is distended. All joints, including the hip, tend, when they are inflamed—whether they contain fluid or whether they do not—to assume

their respective positions of greatest ease.

Speaking of the use of weight extension, Mr. Tobin says that this method "does not act in the way it is represented as doing in the plates in handbooks of surgery. In these," he continues, "you see a patient with a weight attached to the limb lying supine, with his back and knee flat and both touching the mattress. What really happens is this—if the weight is heavy enough to keep the leg straight the spine is dragged into a position of lordosis; if it is less heavy there is less straightening of the limb and less lordosis, in which case the lordosis is an indication of force exerted on the joint to its discomfort." I do not know to what plates in any handbooks Mr. Tobin would have fully justified its introduction, is passed over without notice, so that the mistake which Mr. Tobin has in view is not made. It is 21 years ago since in the Huterian Lectures, delivered at the College of Surgeons, I pointed out that when weight extension is applied while the limb is in the position which Mr. Tobin so justly criticises the force employed acts, not as extension, but as leverage, for the femur is used as a lever, the weight suspended from the foot acts as the power and the acetabulum as the fulcrum, so that instead of relieving pressure between the head of the femur and the acetabulum it tends directly to increase it.

In order to obviate this objectionable condition of things, "when the hip is the affected joint the leg must be extended on the thigh, and the whole limb must be raised till the spine is free from lordosis, and then be supported in this position, the weight being made to act in the long axis of the limb. Then, as the weight gradually reduces the angle of flexion at the joint the apparatus must be rearranged by reducing the height to which the limb is raised, and by changing the position of the pulley so that traction is still maintained in the long axis of the limb. By following out this process the limb will gradually be brought down into a position of full extension.

"It is often surprising to see how

quickly this method of weight extension in the line of the thigh will remove deformity. In recent cases it will reduce the limb to its natural position in ten days or a fortnight, while often in cases of longer standing it will do so in the course of a few weeks." It is quite certain that by weight extension thus applied the limb will be brought down into its correct position within the time occupied by the repair of the femur after Mr. Tobin's osteotomy. This speedy correction of deformity is due to the fact that weight extension re-

moves muscular spasm. When spasm is no longer present the limb is free to return to its normal position.

In a very large number of cases in which early hip disease is adequately treated, complete or very wide movement is retained, and the power of complete extension (together with other movements) is restored, and when this is the case will not the patient be placed at a disadvantage by the fact that his femur has been divided, and made to unite in a position of angular deformity?



Clinical Medicine.

In charge of DR. J. J. MORRISSEY.

THE HEART AND THE WHEEL.

J. J. MORRISSEY, A. M., M. D

The bicycle can no longer be considered a "fad;" it has become an instrument of absolute necessity to a large and constantly growing class of patrons. From a medical standpoint, or rather from a physiological standard, it must be regarded as one of the most useful inventions of the age. It has certainly accomplished more in the way of dissipating the melancholy visions of many a brain-weary mortal than all the pleasant concoctions of medical art. To the student or the business man, whose mind is constantly concentrated on some one department, to the professional man, physician or lawyer, continuously harassed by the obligations of his profession, the bicycle comes as a safeguard in which relaxation, change of scene and environment, the vision of radiant beauties on mountain and vale, in lake and river, in whose depths the very

glories of the Eternal appear to be mirrored, imbues with new life, new aspirations and a complete metamorphosis in the bodily constitution.

These are a few of the advantages to be derived from its proper use. The functional powers of the system are increased and rendered correspondingly more active, the stomach rejoices in an afflux of blood richly intensified by the presence of an abundance of oxygen, and performs its duties with more zeal and vigor; the liver, the great storehouse of the entire system, is stimulated to renewed action, and the products of the metabolic changes which the body is constantly undergoing, instead of remaining within and provoking sources of irritation, are rapidly eliminated. The brain, too, partakes of the renewed activity of the other portions of the system; in fact, there is no class of people so much benefit-

ed by the wheel as those who labor with their heads rather than their hands. Therefore to those of sedentary occupations the use of the wheel is especially beneficial. In this class of people there prevails a condition of chronic cerebral congestion which may be greatly improved and the evil consequences postponed, if not altogether abrogated. The lungs and heart—but here we must issue a note of warning. There is probably no organ of the body to which so much irremediable damage can be done as to the heart in the abuse of the bicycle. In fact it would be well for every person who has ever suffered from acute articular rheumatism to have the heart examined by a competent physician before mounting the bicycle. There are certain forms of cardiac difficulty in which the bicycle, used with the intelligent supervision of a physician, can be made a powerful factor in subduing the disease. The sluggish circulation of the blood in organic heart disease does not supply sufficient oxygen to the system, and hence we have the symptoms, dyspnea, headache, fainting spells, debility and numerous others. And as oxygen is the basis of all tissue building it will be apparent how necessary it is to constantly renew the supply.

Excessive bicycle riding, and especially scorching, is apt to lead to acute dilatation of the left side of the heart, which, however, generally recovers itself when the cause has been removed. But if there is present any changes in the muscular tissue of the heart of a degenerative character the systolic power of the heart is weakened and finally lost, resulting in sudden death. It is a well-known fact that people affected with heart disease, especially with ventricular dilatation, are very susceptible to attacks of pain over the cardiac region when they overtax this organ by ascending mountain elevations, which causes weakened capacity of the heart and great distention. In this connection it may be mentioned that between distention and dilatation there is quite a difference. In distention the cavities are overful, but return to their normal dimensions when the cause

is removed. In dilatation the walls have yielded—one may be a simple physiological process, the other of a pathological character depending upon some antecedent cause. All violent exercise causes the distention of the right heart, and at times the distention is so marked that it requires a considerable period of time before the right heart succeeds in transmitting the blood through the lungs as it is brought to it by the veins. This condition is recognized as "being out of breath." How often do we meet with dilatation with its usual symptom, palpitation, in young people with a history of over exertion, as in bicycling, where efforts are made and maintained beyond the rider's physical powers. If, contrary to advice, he persists in continuing this absolutely injurious form of exercise he will soon find that the wheel has lost its charms and that he is no longer able to ride any distance without great difficulty. In the fatty degeneration of long continued heart disease, as well as in the senile heart, the bicycle should be eschewed, or advised in a selected number of cases. In women approaching menopause, where there is often found an access of heart symptoms due to an arterio-sclerosis—*de la menopause*—and not to the hyperesthetic nervous state of the period, the bicycle could be used with great advantage. This condition of arterial cardiopathy, while it frequently develops insidiously, may show itself suddenly in the form of dyspnea, palpitation and angina, while, if the cerebral vessels are specially attacked, in hemorrhages; if the abdominal viscera, in severe disturbances of those organs, such as congestions, dropsey, uremia and so on.

When the hypertrophied cardiac muscle begins to lose its grasp and grow weak beneath the burden of its great responsibility, judicious use of the wheel may be permitted to a very limited extent, and especially when the hypertrophied condition of the cardiac muscle is associated with the arterial cardiopathy, of which we have spoken above.

These then are a few of the lead-

ing indications concerning the bicycle when used in moderation. It is not its proper use that rightfully is

regarded as an excellent hygienic measure, but its abuse is to be condemned.

Current Medical Literature.

ALIMENTATION IN DISEASE.

BY DR. JAMES C. NIDELET,
St. Louis, Mo.

Recognizing the imperative necessity of proper nourishment in conditions of disease, and particularly when the patient is exhausted from long continued fever, I have made it a practice to resort to the use of Somatose in preference to all other food products. After three years' experience with it I must acknowledge it to be the best nutrient offered to the profession for patients of all ages. I cannot recall any instance in which it was rejected, even when the patient was suffering with nausea. This positive fact renders its use the more available. In the aged, when the appetite is irregular and assimilation indifferent, I regard it superior to stimulants, although the latter should not be ignored if required.

From the numerous cases in which I have employed Somatose I have selected the following as evidence of its beneficial influence:

Case 1.—Mrs. C. N., aged 86 years, was suffering from a severe attack of cholera morbus, having had 21 colliquative passages. She was troubled with constant nausea, all liquids being ejected after repeated trials. Somatose was the only food that was retained and well tolerated. She was sustained on it alone for over 48 hours, after which time thin

soups and milk were allowed. She recovered and is still living at the advanced age of 87 years and three months.

Case 2.—Miss L. H., aged 22 years, had been ill with a continued fever for eight weeks. The stomach was irritable, with constant nausea and inability to retain food of any kind. She was so emaciated and feeble as to be unable to stand without assistance. Somatose was resorted to and even the first dose retained. She continued its use until convalescent and is now enjoying good health.

Case 3.—P. K., a boy 10 years old, also suffered with continued fever, the temperature ranging from 104 to 105 degrees for nearly two weeks. When first seen he was anemic and emaciated, with loss of appetite. Milk was poorly digested and only partially assimilated. Somatose was administered in teaspoonful doses three or four times daily for a number of weeks. It was always well borne and kept up the patient's strength, so that when the fever subsided he was able to get out of bed and stand without assistance.

In conclusion I must reiterate that Somatose fulfills all expectations in sustaining strength and can be administered with the confidence of being retained where everything else fails. I know of no condition in the course of any disease which contraindicates its use.

GLANDULAR FEVER.

Glandular fever was recently the subject of an interesting discussion before the Philadelphia County Medical Society. Dr. Albert E. Roussel (Medical Bulletin), who reported four cases, concluded that we are in reality dealing with a group of symptoms in the main sufficiently distinct to merit the designation of a disease. These cases occurred all in one family and this would seem to emphasize their infectious or contagious nature. It is also notable that one of Dr. Roussel's patients was an adult, as only two other similar cases have been recorded. The temperature records of his cases were rather below those mentioned by other authors, while the pulse rates were somewhat higher. Except, perhaps, in one instance the glandular swelling was unilateral and observed within the first 36 hours. The surrounding skin was normal and in no instance did suppuration result. There was no involvement of glands in other parts of the body, no enlargement of the spleen and liver, and no albumen was present in the urine. Dr. Roussel states that the treatment in these cases is necessarily symptomatic. The use of small doses of calomel at the onset has according to different observers been of particular benefit. He has also made use of a small dose of salophen, which seemed to somewhat relieve the pain and general malaise. The administration of iron is indicated during convalescence. In view of the increasing interest shown in glandular fever during recent years it is well to bear in mind Dr. Roussel's suggestions as to the value of salophen in alleviating the general discomfort.

PAIN AND ITS THERAPEUSIS.

Dr. S. V. Clevenger, after pointing out the disadvantages of various analgesic drugs, states that lacto-

phenin is destined to supersede largely the entire array of analgesics proper, owing to its non-toxic peculiarities and the feeling of comfort described by many physicians as following its use. It affords the best results with the least ill effects. Its range of incompatibility is less than other synthetic compounds and it may be combined with caffeine, quinine and salicylic acid. The minimum dose of 5 to 10 grains may be increased until a daily maximum of 45 grains has been reached. It is but slightly soluble in water, although acting promptly, so that it can be given dry and be washed down with a drink of water. A dose of 15 grains usually acts as a feeble hypnotic. There are no untoward symptoms following its use, and, contrary to the experience with some synthetic drugs, the pulse becomes fuller and stronger under its use. The range of application is extensive, and the testimony of the author is in corroboration of the findings of other physicians as to its superior analgesic effects, its safety and promptness of action.

—R. W. Wilcox, M. D., in American Journal of the Medical Sciences, May, 1897, quoting from Journal of the American Medical Association, 1897, No. 5.

FANDANGOES.

There is too much running after fads in our profession; too much striving after the odd and eccentric; too much antitoxin and serum-therapy and microbe hunting, and Chinese toy-shop apparatus and instruments, and not enough of that placid horse sense which just cures folks and lets the book doctors and instrument inventors give the long-handled names.

N. A. Jour. Hom.

Current Surgical literature.

T. H. MANLEY, M. D., New York, Editor.

OSTEOPATHY.

The Legislature of North Dakota has just passed a law legalizing osteopathy, and the "bone doctor" can now elbow his hitherto arrogant and misguided brother in the regular profession. The professional mind can reconcile itself to the attacks of temporary imbecility which seize upon the public periodically and run their course. The Schlatter craze is a conspicuous example, but it will find it hard to realize that a sovereign State, possessing a common school system, newspapers and other agencies for diffusing knowledge, could enact laws legalizing and giving a quasi respectability to a fraud like this. We extend our sympathy to the profession of a State so publicly insulted by its lawmakers.

—Journal of Arkansas Med. Society.

OBSERVATIONS ON THE CAUSATION OF TRAUMATIC RUPURE OF THE URINARY BLADDER.

V. Stubenrauch has investigated the resistance offered by the bladder to distension by filling it with water under pressure, both in the dead body and in recently killed animals. From these experimental observations and a study of the recorded cases of rupture of the bladder he has arrived at the following conclusions: That for the common traumatic rupture of the bladder there must exist a certain amount of distension of the organ, and the violence applied to it must be of a sufficient degree of intensity. The nature of the violence and the sight of its application are of minor importance. The violence need not even be applied to the bladder itself, for rupture has resulted from a fall

on the buttocks. In 70 out of 154 recorded cases the seat of rupture was in the upper and posterior wall. This situation of the rupture is not to be explained by the viscous being pushed against the sacral promontory. The wall of the bladder would appear to be less resistant in its upper and posterior part, because of the existence of gaps between the bands of longitudinal muscular fibres, and it is possible that the resistance is greater in other parts of the organ, because these are better supported by the surrounding parts, e. g., belly wall, symphysis pubis, spinal column, loaded rectum. The shape and direction of the common rent does not depend upon the nature of the violence, but upon the arrangement of the muscular fibres of the organ. In the process of rupture the mucous membrane would appear to give way first, then the muscular coat, and lastly the peritoneum. In incomplete ruptures the peritoneum remains intact, but it may give way later as the result of over distension, and the rupture becomes complete. This may not take place for several days after receipt of the violence. Cases are recorded in which this occurrence has given rise to serious mistakes in diagnosis and to differences of opinion in medico-legal practice.

—Centralbl. f. Chir., Leipzig, 1897, No. 8; Arch. f. klin. Chir., Berlin, Bd., li. Heft 2.

BIER'S TREATMENT OF TUBERCULOUS ARTHRITIS.

Boutroue (These de Paris, 8 vo., pp. 38, vii Obs., 1896-97, No. 2) records the success of this method in seven cases in Aubeau's clinic at the Hopital International, Paris. The circulation in the affected limb was almost completely arrested every day

or every other day by the application over a layer of cotton wool of an Esmerich bandage above the affected joint for a period of five or six minutes at first, afterward increased, but never exceeding 20 minutes. In the intervals the limb was kept wrapped in cotton wool in a gutta percha splint, but every day or every other day was placed for 20 or 30 minutes in a bath of boiled water kept at a temperature of 50 degrees to 55 degrees C. (122 degrees to 131 degrees F.). In affection of the knee joint the bath was given by hot compresses—10 to 15 layers of tarletan covered with oil silk. To relieve pruritus an ointment of mercury and belladonna was used and suitable constitutional treatment was adopted. Massage was cautiously applied later, the sine qua non being that it should not give pain. Two cases were completely cured, the others greatly improved. Boutrone does not consider the local asphyxia and bath of serum a sufficient explanation of the effects of venous stasis upon tuberculous arthritis. No doubt the formation of fibrous tissue is thus promoted, but a great part of the benefit is due to a sort of auto-sero-therapy by direct action on the tubercle bacillus.

—The British Medical Journal, May 1, 1897

A remarkable case of extravasation of urine is reported by Richard Barwell (Med. Press and Circular). The man, aet. 36, previously to November was perfectly healthy. One night, after coitus, in which nothing unusual occurred, he went to sleep and on waking next morning found the scrotum much swollen. During the next few days the swelling increased. Five days after he had a subnormal temperature, a rather feeble, quick pulse 108, tongue slightly furred, the constitutional symptoms in regard to the local condition being slight, and he said he felt quite well up to four hours ago, and even now only "a little down." The scrotum was greatly distended, boggy to touch, red and studded with blotches here and there of dark brown discoloration. The penis was but slightly swollen, or reddened and free of sloughy spots, while the perineum,

much distended to within a very short distance of the anus, exhibited two sphacelated spots. He asserted that he never had any difficulty in passing urine, which flowed in a full-sized stream. Deep incisions were made in the perineum and scrotum, exposing the superficial muscles of the urethra and the testicles. The sodden tissues were full of urine, with the usual ammoniacal, sloughy odor. One bleeding vessel, being too rotten to bear either torsion or ligature, was secured by leaving it on a pair of forceps; the very soft state of all tissues rendered interference with the urethra inadvisable. Five days after the incisions were made he lost about four ounces of blood by the rupture of a vessel in or close to the right testicle. This depressed his health considerably, but freer stimulation overcame the condition in about eight hours. The rare and interesting features of this case lay in the local condition. Rupture of the urethra, as an immediate result of coitus, had once or twice been reported, but invariably in the penile portion of the tube, never, as far as he was aware, in the membranous part. A No. 12 catheter passed into the bladder without encountering the slightest obstacle, and treatment for the urethra was therefore unnecessary. The man lost by sphacelus about four-fifths of the scrotum, but the parts healed and the whole was quite sound exactly six weeks after, the testicles being enclosed in a new bag, which, though it looked tight, interfered neither with comfort nor function.

SRAINED ANKLE.

BY T. V. GIFFORD, M. D., M. S.,
Kokomo, Ind.

I read Dr. J. B. Ramsey's request for advice in case of a sprained ankle joint. Would say in reply:

Cleanse the bowels every other day with copious injections of warm water, two to four quarts at once. Wrap the foot and ankle in old soft flannel of four or more thicknesses, half way to the knee.

Immerse the limb in a large vessel of water to above the flannel, water to be at 102 to 104 degrees, as can be borne. Add hot water occasion-

ally to keep the desired temperature.

Continue this treatment for an hour once a day. Late in the evening, before retiring, is a good time. At the end of the hour remove the flannel, wrap the foot and ankle in some cotton cloths, four or more thicknesses, wet in warm water; wrap the whole—foot and cloth—in dry flannel, well bound about and made secure with safety pins. This treatment to continue. The hot application for one hour and the bandage for the rest of the time.

—Medical Brief.

A SUBSTITUTE FOR AMPUTA-TION.

A new and simple mode of treatment has been introduced in France by which it is claimed a large proportion of limbs now usually amputated can be saved. The method, which is due to Dr. Reclus, was recently described before the French Congress of Surgery, and is thus explained by the Hospital, April 18 (Lit. Dig.): Whatever the extent or gravity of the lesions he (Dr. Reclus) never under any circumstances amputates the injured limb, but merely wraps it in antiseptic substances by a veritable "embalming" process, leaving nature to separate the dead from the living tissues. This method of treatment possesses the double advantage of being much less fatal than surgical exeresis, and of preserving for the use of the patient, if not the entire limb, at any rate a much larger part than would be left after amputation. He advocates this very conservative treatment on account of the excellent effects of hot water, which he uses freely. After the skin has been shaven and cleansed from all fatty substances by ether, etc., in the usual way, a jet of hot water, 60 degrees to 62 degrees C. (140 degrees to 144 degrees Fahr.), but not higher, is made to irrigate all the injured surfaces, and to penetrate into all the hollows and under all the detached parts of the wound, without exception. This is the only way of removing all clots and to wash away all foreign bodies, together with the micro-organisms they may contain. The advantages of hot water at this high tempera-

ture are threefold: (1) Hot water at this temperature is antiseptic, heat greatly increasing the potency of antiseptic substances; (2) it is hemostatic, (3) it helps to compensate for the loss of heat resulting from the bleeding, and especially from the traumatic shock. After the "embalming" process, and the dead tissue has been separated from the living, the surgeon has nothing to do except to divide the bone at a suitable spot.

—Medical Times.

USES OF COCAIN.

The following practical observations on the surgical use of cocaine are quoted by the American Therapist from the Codex Medicus:

1. The use of cocaine should not be abandoned because its irrational employment has produced deleterious results.
2. Always make a thorough physical examination of the patient before injecting the drug.
3. It should not be used in cases showing organic diseases of the brain, heart, lungs or kidneys, or in persons of neurotic diathesis.
4. Children bear it fully as well as adults.
5. The patient should always be placed in a recumbent position prior to its employment.
6. Constriction should be used whenever possible to limit the action of the drug to the desired area.
7. Use a freshly prepared solution for each case.
8. Distilled water should always be employed, to which phenic, salicylic or boric acid should be added.
9. A 2 per cent. solution has a better effect and is safer than solutions of greater strength.
10. Never inject a larger quantity than one and one-eighth grains when no constriction is used.
11. About the head, face and neck one-third of a grain should never be exceeded.
12. When constriction is possible the dose may be as large as two grains.
13. Every slight physiologic effect is not necessarily to be taken as cause for alarm.

14. Cocain does have effect upon inflamed tissues.

15. In case alarming symptoms occur use amyl nitrite, strychnin, digitalis, ether or ammonia.

To which we will add: Always use a chemically pure product, free from isatropyl and cinnamyl-cocain as well as other impurities, the presence or absence of which can be readily ascertained by the simple tests of the United States pharmacopeia.

—Medical and Surgical Reporter.

THE SURGEON IN HIS RELATION TO THE PUBLIC.

M. O. TERRY, M. D.,
Utica, N. Y.

Unfortunately for human life, its limitation prevents the surgeon from planting in the minds of the profession as firmly as need be any progressive ideas he may have advanced before his presence is demanded in "worlds unknown." At times the idea has been so brilliantly set forth and the clinical support has been so convincing that the ripple of thought will be converted into a wave which takes the profession by storm. At other times the arrest of the magic pen, with its logical current of thought, suspends the progress set in motion until taken up by another. There may be a wise provision in this method of progress which we are not perfectly familiar with, so we will drop that element of destiny and look at the unfortunate surgeon who dares to move in advance, treading under foot the accepted teachings of the past.

Patients are dying daily from neglect, and patients are dying daily from too much enthusiasm with the knife.

Within my remembrance one of America's most brilliant surgeons has snatched from a physician, made famous by his originality of thought in formulating a law, fully one-third of the supposed value of it by simply giving his mind to nerve distribution. It was soon made obvious to this logical thinker that a pathological condition did not always exist at the seat of pain. That a prescription for a reflex pain was in the main ridiculous. That the source of the

pain was the region to relieve by methods either surgical or medical. He has amply proven the truth of his observations by practice, but is yet ridiculed by the majority of the profession, and it will be more than a decade of years after he has been called to other regions before these truths will be fully accepted. The cures made under the new comprehension of facts but show what victims we have made of the public during our onward march from darkness into daylight.

The human body is one vast mystery. With all of our powers of reasoning we cannot comprehend that intelligence which takes charge of our food after it has been placed in the stomach; how the elements needed are abstracted from the emulsion, and those not needed removed; just how we use our brains in almost unconscious locomotion; the nature of the sentinel which presides over respiration, awake or asleep, and so on. It would seem reasonable, in view of our limited comprehension of the processes of life, and it would place us in a less ridiculous light if we should admit at once that the Creator completed his work in the model called man rather than to question his ability in regard to contemplating the anatomical work in question.

—Journal of Official Surgery.

HIGHER MEDICAL EDUCATION.

Higher medical education is being continually sung in our ears by little men in the profession who happen to get onto State Boards of Health and wish to appear great by talking "large on this subject, as if medical education had not steadily advanced most marvelously during the last few decades and as if the equipment of the leading medical schools were not constantly adding to their teaching facilities since the day when Benjamin Rush founded the first medical college in this country, patterned after the best schools of Great Britain, and as if medical men in this country who teach in the best chartered colleges were all incompetent.

It is a strange spectacle to see this everlasting notoriety seeking by

medical men "clothed with a little brief authority," assaulting colleges tenfold better than those they graduated in, with facilities twice as great and far better qualified, equipments far more complete and terms of study lengthened to twice the time they spent as students.

The little fellows of some State Boards are the most clamorous for higher medical education, restrictive legislation and discrimination against the diplomas of the best chartered colleges.

The medical profession cannot be trusted to exercise chartered rights, like other instructors, when instructors secure charters to teach, but must be subjected to additional espionage by State medical detectors called examining boards, and last comes a new proposition to examine the professors, as if the faculties of honorable medical men and boards of trustees controlling our medical colleges required this spying system more than the literary and scientific universities of the land. But if the faculties are to be examined by a board of examiners, who will examine the examiners and attest their qualifications?

Now we are opposed to this whole system of discriminating espionage reflecting on the integrity and qualifications of the teaching element of the United States, and it is a shame that it should come only from medical men, too, who are usually of exceedingly slender qualifications themselves and who wish to appear great in their littleness by defaming American medical education, which, considering that it gets no aid from the State or people, and is in no sense a paying business to those engaged in it, is the best in the world and is making more strides to-day in the direction of the very zenith of practical utility than that of any other country. And what country has such institutions of medical teaching as the United States as the sole result of personal professional effort, zeal and financial support without State aid?

Rush and Jefferson, the universities of Pennsylvania, Virginia, Minnesota, Michigan, Bellevue, Barnes, Baltimore, California, Tulane and in

nearly every city and State are monuments of indefatigable medical devotion and largely disinterested sacrifice of medical time, talent and means, to advance medical education. Every large city on this continent has schools of which Americans may be justly proud, notwithstanding the notes of defamation and puerile cries of suspicion directed from various unhallowed motives against them.

Defamation of American medical colleges by little mediocrities in medicine has about reached the limit of toleration by the friends of medical education in the profession.

The question how to improve and advance is always in order, but late methods of public defamation of American schools is despicable and disastrous to the welfare of the whole medical profession and should be discountenanced and discontinued.

State Boards and schools should arbitrate differences and not antagonize.

Editorial Alchemist and Neurologist,
April, 1897.

NOTES ON VARICOCELE CIR- SOCELE; ITS PATHOLOGY, CLINICAL HISTORY AND TREATMENT.*

BY THOMAS H. MANLEY, M. D.,
New York.
CONCLUSIONS.

1. Varicocele or phlebectasia of the spermatic cord is an infirmity of early life; its evolution being contemporaneous with the advent of sexual activity.

2. Pathologically, while the vesicular inertia, dilatation, thinning, sclerosis, or thrombosis, are quite identical with varix in other situations, in this instance an organ intimately associated with vital processes with procreation and individuality is involved, we have severe local symptoms with reflex disturbances made manifest through psychic derangement.

3. Spermatorrhea, azoo-spermia, limited impotence, urethral irritation and vesical incompetence are not unusual concomitant conditions, and in all protracted cases the testicles are consecutively the seat of organic changes.

4. The pathologic mutations which give rise to the most concentrated distress are a localized phlebitis, periphlebitis, tension and pressure on the medullary and sympathetic nerves, which are sometimes as pronounced in the incipient as in voluminous varicocele.

5. As this condition is not uncommonly associated with rupture, present or impending, the relief of this is something of the highest import,

even by operative procedures, as a truss only aggravates the condition, if it does not sometimes induce it. Bathing, massage, electrolysis and support should be always thoroughly tried, as curative agents first; then, if pain still persist, ligation, excision or divulsion under cocaine is prompt and effective as a radical cure. In all but unusual cases the patient remains at his usual occupation.

—New England Medical Monthly.

Book Reviews.

BOOK ANNOUNCEMENT.

Mr. Moulton begs to announce as in preparation for early publication, "The Doctor's Window," poems by the doctor, for the doctor and about the doctor, edited by Ina Russell Warren. The compilation of this collection has required two years and it contains nearly every poem of importance on the subject in the English language, including: Armstrong's "Art of Preserving Health," Garth's "Dispensary," Henley's "In the Hospital," Dr. Holmes' "The Morning Visit and "Rip Van Winkle, M. D.," Riley's "Doc Sifers," Carleton's "The Country Doctor" and "The Doctor's Story," Eugene Field's "Doctor Rabelais" and "His Pneumogastric Nerve," Peck's "Bessie Brown, M. D." Whittier's "To a Young Physician," and about 75 other standard poems. It also includes a number of powerful poems never before published. Nearly every phase of the physician's life is introduced, both grave and gay. The book will go through the press under the direct supervision of the editor and will be printed with large, open-faced type on heavy linen paper, will be royal octavo in size, 7x9 3-4 inches, and illustrated, making a volume of over 240 pages. The bindings will

be in library style, uncut, gilt top. Price, in cloth, \$2.50; full morocco, \$5.00.

For further information and prospectus address the publisher, Charles Wells Moulton, Buffalo, N. Y.

THE OCCASIONAL ADDRESS, ITS LITERATURE AND COMPOSITION.—A study in demonstrative oratory. By Lorenzo Sears, professor in Brown University. G. P. Putnam's Sons, New York, Publishers.

This work presents, from the analytic and synthetic points of view the requirements for the production of the occasional address. The author has had chiefly in view the needs of the student, but gives suggestions which may be found of service not only to those who may be interested in the study and structure of rhetorical composition, but also in the more serious efforts of the preacher, the lawyer, the political speaker and to the very considerable group of unprofessional citizens who are from time to time called upon to make in spoken words an effective presentation of their thoughts.

Prescriptions.

CORYZA.

In coryza the following sprayed into the nose may be useful:

R—Ichthyol	1 part
Ether	1 part
Alcohol	1 part
Distilled water	97 parts

TREATMENT OF ECZEMA.

At the twenty-third congress of the German Surgical Society, Dr. Rotter recommended the following as an efficient application for the treatment of eczema:

R—Formalin	1 part
Zinc oxide	100 parts
Powdered talc	100 parts
Vaseline	200 parts

MIGRAINE.

For migraine a tablespoonful three times a day of the following may often be given with advantage:

R—Exalgia	1 gr.
Rum	1 fl. oz.
Syrup	1 fl. oz.
Water	4 fl. oz.

TINEA FAVOSA.

Dr. Khrenitchev recommends washing the scalp with tincture of green soap and shaving the affected area. Then the following mixture should be applied. If the hair grows rapidly the shaving may be repeated every two or three days.

R—Acidi carbolic
Balsami peruviani ..	Each 2½ drs.
Petrolei	
Glycerini	Each 3 oz.

M.—Semaine Medicale.

APPLICATION TO PRODUCE LOCAL ANESTHESIA.

R—Chloroform	10 parts
Ether	15 parts
Menthol	1 part

The anaesthesia resulting from this application lasts about five minutes.—Le Gerant and E. Pierre.

—Semaine Medicale.

PULMONARY TUBERCULOSIS.

R—Potassi iodidi	14 grs.
Iodi pur.	15 grs.
Sodii chloridi	1½ drs.
Aqua dist.	2 pints

M. S. Take three or four tablespoonfuls in a glass of milk three to six times daily.—Renzi, Jour. de Med. de Bordeaux.

IRRITABLE BLADDER AFTER CONFINEMENT.

Professor W. E. Fothergill, of Edinburgh, gives a tablespoonful three times a day of the following mixture in post-partum irritability of the bladder:

R—Salol
Tinct. of hyoscyamus..	Each 2 drs.
Infusion of buchu..	q. s. ad. 6 oz.

CHAPPED HANDS.

In Germany the following formula is used for chapped hands, the application being made twice a day:

R—Menthol	10 grs.
Olive oil	
Salol	Each 20 drops

Lanolin

1½ fl. oz.

SMALL-POX.

In treating many small-pox patients, Dr. Th. Faure, surgeon to the hospital at Chaux-de-Fonds, Switzerland, has found that frequent applications to the eruptions of the following iodoform collodion prevent any trace of pitting:

R—Iodoform	30 grs.
Collodion	1 oz.

ULCERS OF THE LEG.

Dr. E. A. Edlen (New York Medical Journal, vol. lxiii) has found the following ointment valuable as an application once a day, and varied in the proportions to suit the case:

R—Carbolic acid	2.0 parts
Boric acid	10.0 parts
Powdered camphor	7.5 parts
Ichthyol	20.0 parts
Oil of citronella	q. s.
Zinc oxide to make up to 100 parts	